DMC PRIMARY CARE
Derry Medical Center

COVID19- EMPLOYEE DAILY SCREENING

TODAY'S DATE: _____ **ORAL TEMPS AM & PM:** _____

Have you experienced any of the following symptoms in the past 24 hours: • fever or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or smell • sore throat • congestion or runny nose • nausea or vomiting • diarrhea	**YES**	**NO**
Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?	**YES**	**NO**
Are you currently waiting on the results of a COVID-19 test?	**YES**	**NO**

Signature _____ Date_____